

Last Name First Name Middle Initial(s)

Street or Mailing Address City

State Zip Code Case Number/Social Security Number

I authorize the release of information regarding my _____ situation to representatives of the Nebraska Department of Health and Human Services. Such privileged information shall be released by: (One source only. Use additional form for each additional source). _____

Only during the one (1) year following the below given date.

Signature of Applicant or Client Date

**SIGN
HERE** ►

Signature of Spouse, if not separated from applicant or client Date

**SIGN
HERE** ►

Signature of Witness Date

**SIGN
HERE** ►



ASD-46 Rev. 11/11 (55001) (Previous version 5/08 should be used first)

Last Name First Name Middle Initial(s)

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